Calhoun County Prescription Plan

Coverage Period: 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs**Coverage for:** Individual+Family | **Plan Type:** Prescription

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **http://calhouncountymi.gov** or by calling **1-269-781-0980**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,500** per individual/ **$3,000** per family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.caremark.com or call 1-866-831-4336** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	No coverage for primary care visit.
	Specialist visit	Not covered	Not covered	No coverage for specialist visit.
	Other practitioner office visit	Not covered	Not covered	No coverage for other practitioner office visit.
	Preventive care/screening/immunization	Not covered	Not covered	No coverage for preventive care / screening / immunization.
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	No coverage for diagnostic tests.
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	No coverage for imaging.

Common Medical Event	Services You May Need	Your cost if you use a In Network Provider	Your cost if you use a Out of Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10 copay/ prescription retail; $20 copay/ prescription mail order	$10 copay. Retail only	Covers up to a 34-day supply (retail prescription); 34-90 day supply (mail order prescription) Certain diabetic supplies covered with **$0** copay.
	Preferred brand drugs	$20 copay/ prescription retail; $40 copay/ prescription mail order	$20 copay. Retail only	Covers up to a 34-day supply (retail prescription); 34-90 day supply (mail order prescription).
	Non-preferred brand drugs	$40 copay/ prescription retail; $80 copay/ prescription mail order	$40 copay. Retail only	Covers up to a 34-day supply (retail prescription); 34-90 day supply (mail order prescription).
	Specialty drugs	$10 Generic, $20 Preferred, $40 Non-preferred	Not covered	Requires use of Caremark Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage for facility fee.
	Physician/surgeon fees	Not covered	Not covered	No coverage for outpatient surgery.
If you need immediate medical attention	Emergency room services	Not covered	Not covered	No coverage for emergency room services.
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation.
	Urgent care	Not covered	Not covered	No coverage for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage for facility fee.
	Physician/surgeon fee	Not covered	Not covered	No coverage for physician / surgeon fee.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In Network Provider	Out of Network Provider	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	No coverage for mental/behavioral health outpatient services.
	Mental/Behavioral health inpatient services	Not covered	Not covered	No coverage for mental/behavioral health inpatient services.
	Substance use disorder outpatient services	Not covered	Not covered	No coverage for substance use disorder outpatient services.
	Substance use disorder inpatient services	Not covered	Not covered	No coverage for substance use disorder inpatient services.
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	No coverage for prenatal and postnatal care.
	Delivery and all inpatient services	Not covered	Not covered	No coverage for delivery and all inpatient services.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care.
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care.
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment.
	Hospice service	Not covered	Not covered	No coverage for hospice service.
If your child needs dental or eye care	Eye exam	Not covered	Not Covered	No coverage for eye exam.
	Glasses	Not covered	Not Covered	No coverage for glasses.
	Dental check-up	Not covered	Not Covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult/child)
- Diagnostic test (x-ray, blood work)
- Durable medical equipment
- Emergency medical transportation
- Emergency room services
- Habilitation services
- Hearing aids
- Home health care
- Hospice service
- Hospital stay – facility fee
- Hospital stay – physician / surgeon fee
- Imaging (CT / PET scans, MRIs)
- Infertility treatment
- Long-term care
- Mental / behavioral health outpatient services
- Mental / behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Other practitioner office or clinic visits
- Outpatient surgery – facility fee
- Outpatient surgery – physician / surgeon fee
- Pregnancy – prenatal and postnatal care
- Pregnancy – delivery and all inpatient services
- Preventive care / screening / immunizations in a health care provider's office or clinic
- Primary care office or clinic visits
- Private-duty nursing
- Rehabilitation services
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care
- Specialist office or clinic visits
- Substance use disorder outpatient services
- Substance use disorder inpatient services
- Urgent care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Most coverage provided outside the United States. See www.Caremark.com

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-831-4336. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: CVS/Caremark, P.O. Box 52084 Phoenix, AZ 85072-2084. Calhoun County, Attention: Plan Sponsor/ Human Resources Department, 315 W. Green St. Marshall, MI 49068 or 269-781-0980. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services

To get help reading in your language call the customer service number on the back of your ID card.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This plan or policy does not meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans. This assumes individual coverage is selected.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $80
- **Patient pays** $7,460

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$7,440
Total	**$7,460**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,360
- **Patient pays** $ 3,040

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$0
Limits or exclusions	$2,640
Total	**$3,040**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.